Notice of Independent Review Decision

Date notice sent to all parties: June 26, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Injection(2), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., board certified in Neurology with Added Qualifications in Pain Management, fellowship trained in Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld **(Agree)**
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

See explanation below for determination that the injections(s) as described above are not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Certification of independence of the reviewer.
2. TDI case assignment.
3. Letters of denial 05/07/12 & 05/22/12, including criteria used in the denial.
4. Medical records reviews (not dated): Anesthesiologyt/Pain Management.
5. Range of motion 04/23/12.
6. Initial interview 04/26/12.
7. Request for reconsideration 05/14/12.
8. Request for independent review 06/12/12.

PATIENT CLINICAL HISTORY [SUMMARY]:
This claimant sustained a work-related injury on xx/xx/xx with current complaints that include low back pain and neck pain with some radicular symptomatology including the right shoulder and upper extremity as well as lumbar radicular symptoms. The most recent imaging reports by MRI scan indicate degenerative spondylosis and spondylolisthesis at multiple levels in the lumbar spine with bilateral foraminal stenosis, disc extrusion, facet hypertrophic arthropathy, and postoperative changes, as well. Cervical spine MRI scan also done recently shows multilevel spondylosis also with central canal stenosis as well as foraminal narrowing at multiple sites due

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to a combination of facet arthropathy, five disc degenerative changes, bone spurring, etc. The most recent treatment recommendations have included transforaminal epidural steroid injections at both cervical and lumbar levels under fluoroscopic guidance and with sedation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

I agree with prior reviewers that the requested transforaminal epidural steroid injections of both the cervical and lumbar levels are not warranted. The structural changes seen on the most recent imaging studies suggest chronic disease that is not necessarily expected at this point to reverse on its own with conservative management. Though the epidural steroid injections may conceivably result in some symptomatic improvement, this will, in all likelihood, be only temporary and will not result in any significant long term improvement. The structural abnormalities seen on imaging are of a chronic nature and would not be expected to undergo any significant reversal over time, especially the chronic bony and arthritic changes to the facet joints, etc. Other reservations on the prior denials include the overall steroid exposure, especially if the cervical and lumbar injections are done on the same day or at the same time. I agree that this would be reasonable to avoid. An argument could also be made that additional volume of material being injected may actually result in greater compression, especially with some central spinal stenosis also noted on imaging at both the cervical and lumbar levels.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- **X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- **X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

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